FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038711

Facility Name: Embassy Care Center, Inc

Address: 555 Kahler Road (Number) Wilmington (City) 60481 (Zip Code)

County: Will

Telephone Number: (815) 476-7931 **Fax #** (815) 476-7939

IDPA ID Number: 36-3863655-001

Date of Initial License for Current Owners: 02/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Bob Kagda **Telephone Number:** (847)-675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Bob Kagda, Partner

(Firm Name & Address) Krupnick, Bokor, Kagda & Brooks, Ltd. 3750 W. Devon Ave. Lincolnwood, Il 60712-1124

(Telephone) (847)-675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3	91	Intermediate (ICF)	91	33,215	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,415	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,000	90	2,680	13,770	8
9	SNF/PED					9
10	ICF		26,347	716	27,063	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,000	26,437	3,396	40,833	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.42%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 2,680

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	196,887	12,652	8,030	217,569		217,569		217,569			1
2	Food Purchase		193,202		193,202	(26,345)	166,857	(521)	166,336			2
3	Housekeeping	131,870	35,601		167,471		167,471		167,471			3
4	Laundry	75,146	25,464		100,610		100,610		100,610			4
5	Heat and Other Utilities			107,854	107,854		107,854	(3,370)	104,484			5
6	Maintenance	40,817	6,902	28,962	76,681		76,681	8,454	85,135			6
7	Other (specify):*											7
8	**TOTAL General Services**	444,720	273,821	144,846	863,387	(26,345)	837,042	4,563	841,605			8
	B. Health Care and Programs											
9	Medical Director			5,000	5,000		5,000		5,000			9
10	Nursing and Medical Records	1,024,673	64,368	452,386	1,541,427		1,541,427	(2,391)	1,539,036			10
10a	Therapy	76,845	1,376	16,972	95,193		95,193		95,193			10a
11	Activities	91,711	5,828	1,404	98,943		98,943		98,943			11
12	Social Services	38,096		6,199	44,295		44,295		44,295			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,231,325	71,572	481,961	1,784,858		1,784,858	(2,391)	1,782,467			16
	C. General Administration											
17	Administrative	72,857		312,854	385,711		385,711	(259,934)	125,777			17
18	Directors Fees											18
19	Professional Services			47,804	47,804		47,804	1,256	49,060			19
20	Dues, Fees, Subscriptions & Promotions			13,548	13,548		13,548	(5,304)	8,244			20
21	Clerical & General Office Expenses	118,422	14,381	28,588	161,391		161,391	67,662	229,053			21
22	Employee Benefits & Payroll Taxes			319,558	319,558	26,345	345,903	15,400	361,303			22
23	Inservice Training & Education											23
24	Travel and Seminar			248	248		248	(100)	148			24
25	Other Admin. Staff Transportation			19,675	19,675		19,675	1,446	21,121			25
26	Insurance-Prop.Liab.Malpractice			147,246	147,246		147,246	1,249	148,495			26
27	Other (specify):*											27
28	**TOTAL General Administration**	191,279	14,381	889,521	1,095,181	26,345	1,121,526	(178,325)	943,201			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,867,324	359,774	1,516,328	3,743,426		3,743,426	(176,153)	3,567,273			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Embassy Care Center, Inc
0038711
COST REPORT RECLASSIFICATIONS
01/01/03
12/31/03

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	26,345	
2	FOOD		26,345

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number Embassy Care Center, Inc #0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			43,681	43,681		43,681	100,537	144,218			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,919	52,919		52,919	489,668	542,587			32
33	Real Estate Taxes			66,852	66,852		66,852	5,261	72,113			33
34	Rent-Facility & Grounds			560,594	560,594		560,594	(560,594)				34
35	Rent-Equipment & Vehicles							1,412	1,412			35
36	Other (specify):*											36
37	**TOTAL Ownership**			724,046	724,046		724,046	36,284	760,330			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		94,530	55,204	149,734		149,734		149,734			39
40	Barber and Beauty Shops			1,442	1,442		1,442		1,442			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			93,623	93,623		93,623		93,623			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		94,530	150,269	244,799		244,799		244,799			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,867,324	454,304	2,390,643	4,712,271		4,712,271	(139,869)	4,572,402			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,779	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(521)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,802)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	557	21		24
25	Fund Raising, Advertising and Promotional	(2,093)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(84,157)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,237)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(66,632)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (66,632)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (139,869)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Embassy Care Center, Inc

ID# 0038711

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	From Embassy Building Partnership:	$		1
2	Trust Fees	(360)	21	2
3	Bank Charges	(718)	21	3
4	Non Patient Care - Interest Exp	(9,969)	32	4
5	R E Taxes	(3,861)	33	5
6	Mtgre Costs	(5,630)	32	6
7	Depreciation House	(3,846)	30	7
8	754 Depreciation	(9,278)	30	8
9				9
10	Veterans Expense	(2,391)	10	10
11	Prior Year Legal bills	(181)	19	11
12	Entertainment	(3,175)	20	12
13	Bank Charges	(8,429)	21	13
14	Interst Income	(24)	32	14
15	Marketing Salaries	(30,747)	21	15
16				16
17	Deferred Maintenance	4,255	6	17
18	Deferred Maintenance	(690)	6	18
19	Void Checks			19
20	Void Checks	(223)	20	20
21	Void Checks	(100)	24	21
22	Void Checks	(1,470)	19	22
23	Void Checks	(925)	6	23
24	Void Checks	(267)	22	24
25	Void Checks	(6,128)	5	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(84,157)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(521)	0	0	0	0	0	0	0	0	0	0	(521)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,128)	0	2,758	0	0	0	0	0	0	0	0	(3,370)	5
6	Maintenance	2,640	0	5,814	0	0	0	0	0	0	0	0	8,454	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,009)	0	8,572	0	0	0	0	0	0	0	0	4,563	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,391)	0	0	0	0	0	0	0	0	0	0	(2,391)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,391)	0	0	0	0	0	0	0	0	0	0	(2,391)	16
	C. General Administration													
17	Administrative	0	0	(259,934)	0	0	0	0	0	0	0	0	(259,934)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,651)	360	2,547	0	0	0	0	0	0	0	0	1,256	19
20	Fees, Subscriptions & Promotions	(5,491)	0	187	0	0	0	0	0	0	0	0	(5,304)	20
21	Clerical & General Office Expenses	(43,499)	1,237	109,924	0	0	0	0	0	0	0	0	67,662	21
22	Employee Benefits & Payroll Taxes	(267)	0	15,667	0	0	0	0	0	0	0	0	15,400	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(100)	0	0	0	0	0	0	0	0	0	0	(100)	24
25	Other Admin. Staff Transportation	0	0	1,446	0	0	0	0	0	0	0	0	1,446	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,249	0	0	0	0	0	0	0	0	1,249	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(51,008)	1,597	(128,914)	0	0	0	0	0	0	0	0	(178,325)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(57,408)	1,597	(120,342)	0	0	0	0	0	0	0	0	(176,153)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Embassy Care Center, Inc # 0038711 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,655	88,140	8,742	0	0	0	0	0	0	0	0	100,537	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,623)	497,812	7,479	0	0	0	0	0	0	0	0	489,668	32
33	Real Estate Taxes	(3,861)	3,861	5,261	0	0	0	0	0	0	0	0	5,261	33
34	Rent-Facility & Grounds	0	(560,594)	0	0	0	0	0	0	0	0	0	(560,594)	34
35	Rent-Equipment & Vehicles	0	0	1,412	0	0	0	0	0	0	0	0	1,412	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(15,829)	29,219	22,894	0	0	0	0	0	0	0	0	36,284	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(73,237)	30,816	(97,448)	0	0	0	0	0	0	0	0	(139,869)	45

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule		See Schedule		See schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 560,594			$	$ (560,594)	1
2	V	19	Acctg		Embassy Care LLC		360	360	2
3	V	21	Bank Charges		Embassy Care LLC		718	718	3
4	V	21	Trust Fees		Embassy Care LLC		519	519	4
5	V	32	Interest Expense		Embassy Care LLC		492,182	492,182	5
6	V	33	RE Tax		Embassy Care LLC		3,861	3,861	6
7	V	30	Depreciation		Embassy Care LLC		88,140	88,140	7
8	V	32	Amort Mtge Costs		Embassy Care LLC		5,630	5,630	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 560,594			$ 591,410	$ * 30,816	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 312,854	Future Associates		$	$ (312,854)	15
16	V	5	Utilities		Future Associates		2,758	2,758	16
17	V	6	Maintenance		Future Associates		5,814	5,814	17
18	V	17	Administrative		Future Associates		52,920	52,920	18
19	V	19	Professional Fees		Future Associates		2,547	2,547	19
20	V	21	Clerical and General		Future Associates		109,924	109,924	20
21	V	22	Employee Benefits		Future Associates		15,667	15,667	21
22	V	25	Auto Expense		Future Associates		1,446	1,446	22
23	V	26	Insurance Expense		Future Associates		1,249	1,249	23
24	V	30	Depreciation		Future Associates		8,742	8,742	24
25	V	32	Interest Expense		Future Associates		7,479	7,479	25
26	V	33	Real Estate Taxes		Future Associates		5,261	5,261	26
27	V	35	Equipment Rental		Future Associates		1,412	1,412	27
28	V	20	License, Dues, Fees		Future Associates		187	187	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 312,854			$ 215,406	$ * (97,448)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Haim Perlstein	Director	Administrative	22.96	See attached	27	45.00	Admin	$ 52,920	17-7	1
2											2
3	Nachshon Draiman	Director	Administrative	70.40							3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 52,920		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Future Associates
Street Address: 7514 N. Skokie Blvd
City / State / Zip Code: Skokie, Il
Phone Number: (847)982-1195
Fax Number: (847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Management Fees	1,083,202	4	$ 9,550	$	312,854	$ 2,758	1
2	6	Maintenance	Management Fees	1,083,202	4	20,131		312,854	5,814	2
3	17	Administrative	Direct allocation		3	261,600			52,920	3
4	19	Professional Fees	Management Fees	1,083,202	4	8,817		312,854	2,547	4
5	21	Clerical and General	Management Fees	1,083,202	4	380,592	310,233	312,854	109,924	5
6	22	Employee Benefits	Management Fees	1,083,202	4	54,245		312,854	15,667	6
7	25	Auto Expense	Management Fees	1,083,202	4	5,005		312,854	1,446	7
8	26	Insurance Expense	Management Fees	1,083,202	4	4,326		312,854	1,249	8
9	30	Depreciation	Management Fees	1,083,202	4	30,268		312,854	8,742	9
10	32	Interest Expense	Management Fees	1,083,202	4	25,895		312,854	7,479	10
11	33	Real Estate Taxes	Management Fees	1,083,202	4	18,214		312,854	5,261	11
12	35	Equipment Rental	Management Fees	1,083,202	4	4,889		312,854	1,412	12
13	20	License, Dues, Fees	Management Fees	1,083,202	4	649		312,854	187	13
14	21	Clerical and General	Direct allocation			46,710	46,710			14
15	22	Employee Benefits	Direct allocation			3,753				15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 874,644	$ 356,943		$ 215,406	25

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIB Bank		X	Mortgage	$43,220.44	12/30/99	$ 4,510,000	$ 4,172,433		9.7500	$ 452,901	1
2	IDPA		X								8,183	2
3												3
4	Allocation from Future										7,479	4
5												5
	Working Capital											
6	Hawthorn Bank		X	Working Capital						Various	29,311	6
7	CIB Bank		X	Working Capital	Dec-99					Various	38,518	7
8	Insurance		X								6,219	8
9	TOTAL Facility Related				$79,715.44		$ 4,510,000	$ 4,172,433			$ 542,611	9
	B. Non-Facility Related*											
10												10
11	Interest Income										(24)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (24)	14
15	TOTALS (line 9+line14)						$ 4,510,000	$ 4,172,433			$ 542,587	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ None** **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Embassy Care Center, Inc # 0038711 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	60,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	68,613	2
3. Under or (over) accrual (line 2 minus line 1).	$	8,113	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	64,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	72,113	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	53,454	8
	1999	54,781	9
	2000	56,677	10
	2001	60,323	11
	2002	63,352	12

Estimate based on 2002 bill adjusted to 64,000

Allocation from Future 5,261

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Embassy Care Center, Inc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0038711

CONTACT PERSON REGARDING THIS REPORT Bob Kagda

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-36-300-010-0000	Nursing Home	$ 63,351.60	$ 63,351.60
2.	10-28-408-025	Management Office	$ 17,915.80	$ 1,469.00
3.	10-28-408-026	Management Office	$ 8,751.07	$ 717.00
4.	10-28-408-027	Management Office	$ 8,751.07	$ 717.00
5.	10-28-408-028	Management Office	$ 12,701.72	$ 1,041.00
6.	10-28-408-029	Management Office	$ 12,701.72	$ 1,041.00
7.	10-28-408-030	Management Office	$ 1,522.14	$ 125.00
8.	10-28-408-031	Management Office	$ 1,522.14	$ 125.00
9.			$	$
10.			$	$
		TOTALS	$ 127,217.26	$ 68,586.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1193	$ 145,000	1
2					2
3	TOTALS			$ 145,000	3

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	171		1993		$ 2,363,000	$ 75,016	35	$ 67,514	$ (7,502)	$ 737,028	4
5											5
6	Alloc LCF			1986	62,771	2,636	30	2,093	(543)	35,745	6
7	Alloc LCF			1987	1,506	48	31.5	48		789	7
8											8
	Improvement Type**										
9	Various			1993	55,674	1,098	20	2,784	1,686	29,129	9
10	Various			1994	144,492	2,935	20	7,225	4,290	68,923	10
11	Various			1995	126,250	3,225	20	6,313	3,088	53,445	11
12	Various			1996	94,458	2,424	20	4,725	2,301	35,699	12
13	Various			1997	13,974	359	20	696	337	4,782	13
14	Various			1998	13,694	218	20	685	467	3,699	14
15	Various			1999	29,626	760	20	1,480	720	6,485	15
16	Clean floors			5/16/2000	872	22	20	88	66	320	16
17	100 A 240 V 3 POLE			6/27/2000	809	21	20	40	19	144	17
18	Painting & Decor			6/30/2000	44,888		20	2,244	2,244	6,793	18
19	Single stage furnace			8/15/2000	2,891	74	20	145	71	494	19
20	Hot water heater			11/7/2000	2,500	64	20	250	186	792	20
21	Nurse call system			11/10/2000	750	20	20	38	18	119	21
22	Install h/water htr			11/16/2000	850	21	20	43	22	135	22
23	New Grease Trap			12/8/2000	15,037	386	20	752	366	2,319	23
24	Alarm system			7/31/2001	1,691	44	20	84	40	212	24
25	Sewer rodding			11/5/2001	1,265	33	20	63	30	137	25
26	Wire fire alarm system			11/12/2001	756	19	20	20	1	45	26
27	CCTV service			11/12/2001	945	24	20	47	23	102	27
28	Alarm system			2/27/2002	1,466	37	20	73	36	134	28
29	Exterior sewer connection			1/24/2003	8,498	209	20	212	3	212	29
30	Rooftop Htg. Unit Module			2/24/2003	768	17	20	19	2	19	30
31	Rooftop compressor unit			5/17/2003	1,250	20	20	31	11	31	31
32	Hood suppression system			6/6/2003	1,489	21	20	37	16	37	32
33	CCTV monitoring system			6/23/2003	1,409	20	20	35	15	35	33
34	New roof			7/29/2003	25,000	294	20	625	331	625	34
35	Smoke detectors, door holders			11/28/2003	805	3	20	20	17	20	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Allocation from LCF	1987	$ 8,639	$ 274	31.5	$ 274	$	$ 4,456	37
38	Allocation from LCF	1988	485	15	31.5	15		236	38
39	Allocation from LCF	1989	181	6	31.5	6		82	39
40	Allocation from LCF	1993	5,018	129	39	129		1,333	40
41	Allocation from LCF	1994	7,652	196	39	196		1,855	41
42	Allocation from LCF-Air Cond; Roof repairs	2001	2,131	55	39	55		136	42
43	Allocation from LCF-5 Ton Trane A/C	2002	522	13	39	13		18	43
44	Allocation from LCF-Office Remodeling	2003	164		39				44
45	Allocation From Future	1987	27,226	864	31.5	878	14	14,830	45
46	Allocation From Future	1994	7,963	108	Var	483	375	4,777	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,079,365	$ 91,728		$ 100,478	$ 8,750	$ 1,016,172	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 360,134	$ 28,221	$ 36,505	$ 8,284	10	$ 216,853	71
72	Current Year Purchases	8,807	1,761	440	(1,321)	10	440	72
73	Fully Depreciated Assets	476,139		2,941	2,941	10	476,139	73
74								74
75	TOTALS	$ 845,080	$ 29,982	$ 39,886	$ 9,904		$ 693,432	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus		6/16/1998	$ 1,200	$ 69	$ 69	$	5	$ 1,200	76
77	Van	Dodge Caravan	4/7/2003	18,750	3,750	1,875	(1,875)	5	1,875	77
78	Alloc from Future			55,734	1,909	1,909			33,119	78
79										79
80	TOTALS			$ 75,684	$ 5,728	$ 3,853	$ (1,875)		$ 36,194	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,145,129	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 127,438	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 144,217	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,779	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,745,798	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Future		$	$ 1,412	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,412	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 13,185	$		$ 13,185	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,690			3,690	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			35,291			35,291	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				81,092		81,092	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med Supplies					3,038	13,438		16,476	13
14	TOTAL			$		$ 55,204	$ 94,530		$ 149,734	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Embassy Care Center, Inc **0038711**

1/1/2003 to ########

Special Services - Other (Col 6)	Reference	
Medical Supplies	39-2	13438
Total		13438

Special Services - Other (Col 5)		
Lab & Xray	39-3	2588
Other Medicare	39-3	450
Total		3038

Facility Name & ID Number Embassy Care Center, Inc # 0038711 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,593	$ 9,540	1
2	Cash-Patient Deposits	39,948	39,948	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,000)	645,816	660,431	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	162,703	162,703	6
7	Other Prepaid Expenses	4,472	4,472	7
8	Accounts Receivable (owners or related parties)	1,125,738	2,010,207	8
9	Other(specify):	36,933	45,304	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,023,203	$ 2,932,605	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		149,058	13
14	Buildings, at Historical Cost		2,874,827	14
15	Leasehold Improvements, at Historical Cost	498,847	498,847	15
16	Equipment, at Historical Cost	403,353	795,353	16
17	Accumulated Depreciation (book methods)	(435,247)	(1,730,285)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Utility Dep	3,478	3,478	22
23	Other(specify): Mtge Costs		90,086	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 470,431	$ 2,681,364	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,493,634	$ 5,613,969	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,378,152	$ 1,400,225	26
27	Officer's Accounts Payable	2,092,625		27
28	Accounts Payable-Patient Deposits	34,457	34,457	28
29	Short-Term Notes Payable	477,028	929,772	29
30	Accrued Salaries Payable	152,039	152,039	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,037	29,037	31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,000	67,500	32
33	Accrued Interest Payable	4,571	41,996	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Schedule attached			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,231,909	$ 2,655,026	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,283,378	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Schedule attached			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,283,378	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,231,909	$ 6,938,404	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,738,275)	$ (1,324,435)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,493,634	$ 5,613,969	48

***(See instructions.)**

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES As of 12/31/03

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	22,073	30,444
Employee Advances	2,342	2,342
Deferred Federal Taxes	12,518	12,518
	36,933	45,304

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		

OTHER NON CURRENT ASSETS:

Construction In Progress
Utility Deposit
Loan Costs

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,498,550)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,498,550)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(239,727)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (239,727)	17
	B. Transfers (Itemize):		
18	**Round off Adjustment**	2	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,738,275)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Nur	Embassy Care Center, Inc	#	0038711	Report Period Beginning:	01/01/03	Ending:	12/31/03

Balance per General Ledger		
Adjustments:		
		-
		-
		-
Round Off Adj		
Total adjustments		-
Balance - Beginning of Year		-
Equity(Deficit) from Page 17 Col 1		(1,738,275)
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		(1,738,275)

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,417,969	1
2	Discounts and Allowances for all Levels	(203,537)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,214,432	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	141,685	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 141,685	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,853	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	66,866	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	48,231	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 116,950	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Schedule attached	(547)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (547)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,472,544	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	863,387	31
32	Health Care	1,784,858	32
33	General Administration	1,095,181	33
	B. Capital Expense		
34	Ownership	724,046	34
	C. Ancillary Expense		
35	Special Cost Centers	151,176	35
36	Provider Participation Fee	93,623	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,712,271	40
41	**Income before Income Taxes (line 30 minus line 40)****	(239,727)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (239,727)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **Embassy Care Center, Inc** **# 0038711** **Report Period Beginning:** **01/01/03** **Ending:** **12/31/03**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/03

	DESCRIPTION		AMOUNT
1	Vending Commissions		
2	Adj of Prior period Income and Expenses:		
3	Income		9,274
4	Expenses	Dr Adj	387
5		Cr Adj	(9,114)
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
	TOTALS		547

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,780	2,020	$ 52,810	$ 26.14	1
2	Assistant Director of Nursing	1,443	1,589	35,750	22.50	2
3	Registered Nurses	4,472	4,829	96,390	19.96	3
4	Licensed Practical Nurses	15,470	16,762	298,874	17.83	4
5	Nurse Aides & Orderlies	51,077	54,631	540,849	9.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,105	5,688	76,845	13.51	8
9	Activity Director	3,331	3,966	39,301	9.91	9
10	Activity Assistants	7,036	7,392	52,410	7.09	10
11	Social Service Workers	3,508	3,911	38,096	9.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,430	23,664	196,887	8.32	15
16	Dishwashers					16
17	Maintenance Workers	3,171	3,622	40,817	11.27	17
18	Housekeepers	16,497	18,139	131,870	7.27	18
19	Laundry	10,227	11,051	75,146	6.80	19
20	Administrator	4,092	4,278	72,857	17.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,952	9,907	87,675	8.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	1,855	2,134	30,747	14.41	33
34	TOTAL (lines 1 - 33)	159,446	173,583	$ 1,867,324 *	$ 10.76	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	156	$ 8,030	1-3	35
36	Medical Director	Monthly	5,000	9-3	36
37	Medical Records Consultant	8	600	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,500	10-3	39
40	Physical Therapy Consultant	72	16,499	10a-3	40
41	Occupational Therapy Consultant	24	472	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	1,404	11-3	44
45	Social Service Consultant	84	6,199	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	381	$ 39,704		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,905	$ 97,529	10-3	50
51	Licensed Practical Nurses	4,469	121,878	10-3	51
52	Nurse Aides	12,230	230,880	10-3	52
53	TOTAL (lines 50 - 52)	20,604	$ 450,287		53

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing	1,855	2,134	$ 30,747	$ 14.41
	1,855	2,134	$ 30,747	$ 14.41

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Bersted	Admin	0	$ 38,419
Sandra Juhl	Admin	0	27,191
Barb Faron	Admin	0	9,450
Year end Accrual Adjustment			(2,203)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,857

B. Administrative - Other

Description	Amount
Future Associates	$ 312,854
TOTAL (agree to Schedule V, line 17, col. 3)	$ 312,854
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Krupnick,Bokor, Kagda, & Brooks	Acctg	$ 7,250
L J Cohn	Acctg	9,923
R Peelo	Medicare Acctg	2,800
Various	Data Processing Fees	16,990
Personnel Planners	UC Consultant	1,963
Neal, Gerber & Eisenberg	Legal	2,306
Sachnoff & Weaver LTD	Legal	6,572
Schedule attached		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 47,804

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,843
Unemployment Compensation Insurance	12,100
FICA Taxes	142,817
Employee Health Insurance	78,914
Employee Meals	26,345
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	2,726
Employee Benefits	158
Allocation from Future	15,667
Void check	(267)
TOTAL (agree to Schedule V, line 22, col.8)	$ 361,303

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,954
Health Care Worker Background Check	
(Indicate # of checks performed 20)	246
Advertising	2,158
Dues and Subscriptions	361
Meals	3,175
Licenses and Fees	1,654
Allocation from Future	187
Void checks	(223)
Less: Public Relations Expense	( )
Non-allowable advertising	(5,268)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,244

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	148
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 148

* Attach copy of IMRF notifications

**See instructions.

Page 21- Professional Services:

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Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Painting & Decorating	6/99	$ 16,586	3	$ 2,764	$ 5,529	$ 5,529	$ 2,764	$	$	$	$	$
2	Painting & Decorating	6/01	2,347	3		391	782	782	392				
3	Painting & Decorating	6/02	1,781	3			297	594	593	297			
4	Painting & Decorating	6/03	690	3				115	230	230	115		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 21,404		$ 2,764	$ 5,920	$ 6,608	$ 4,255	$ 1,215	$ 527	$ 115	$	$